MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

APPLICATION FOR HOME HEALTH AGENCY LICENSE

In accordance with the requirements of the Missouri Home Health Agency Licensing Law (Chapter 197, RSMo Cumulative Supp. 1983) Regulations and Codes, application is hereby made for a license to conduct and maintain a Home Health Agency (See Missouri Home Health Agency Licensing Law "Definitions", Section 197.400.)

THIS INFORMATION, WITHOUT FURTHER VERIFICATION, WILL BE PROVIDED TO BOTH MEDICARE AND MEDICAID OFFICES AND TO UPDATE THE STATE HOME HEALTH DIRECTORY.

NAME OF AGENCY	TELEPHONE NO.
ADDRESS (STREET, CITY, STATE, ZIP)	COUNTY

HOME HEALTH AGENCY ADMINISTRATOR	SUPERVISORY NURSE	ADMINISTRATOR's EMAIL ADDRESS

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

GOVERNMENTAL

- ☐ COUNTY
- ☐ CITY-COUNTY
- ☐ CITY
- ☐ DISTRICT

NON-GOVERNMENTAL

NON-PROFIT
- ☐ CORPORATION
- ☐ OTHER (EXPLAIN) _____

PROPRIETARY
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION

☐ FREESTANDING AGENCY ☐ HOSPITAL-BASED AGENCY ☐ SNF/ICF BASED AGENCY ☐ REHABILITATION FACILITY-BASED AGENCY

CHIEF OFFICER OF GOVERNING BODY

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

GEOGRAPHIC AREA COVERED BY AGENCY OPERATION

LIST COUNTY(IES).

PROFESSIONAL SERVICES (Indicate ALL services offered by agency)

Place a "1" in the block for each service provided by AGENCY STAFF or by contract with an individual. If services are provided UNDER ARRANGEMENT with another agency, place a "2" in the block.

- ☐ NURSING CARE
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ SPEECH THERAPY
- ☐ MEDICAL SOCIAL SERVICES
- ☐ HOME HEALTH AIDE SERVICE
- ☐ OTHER (SPECIFY) _____

DIRECT PROFESSIONAL SERVICE (Indicate your agency's direct service) **(Choose only one)**

- ☐ NURSING CARE
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ SPEECH THERAPY
- ☐ MEDICAL SOCIAL SERVICES
- ☐ HOME HEALTH AIDE SERVICE
- ☐ OTHER (SPECIFY) _____

MEDICARE/MEDICAID PARTICIPATION

Is this agency Medicare certified? ☐ Yes ☐ No
If yes, list Medicare provider number_____
Is this agency Medicaid certified? ☐ Yes ☐ No
If yes, list Medicaid provider number_____

Number of Employees on the Agency Staff (Full-Time Equivalents). If service is provided by non-employees enter "BY MANAGEMENT."

A. REGISTERED PROFESSIONAL NURSES	C. QUALIFIED PHYSICAL THERAPISTS	E. QUALIFIED SPEECH PATHOLOGIST OR AUDIOLOGIST	
B. LPN/LICENSED VOCATIONAL NURSES	D. QUALIFIED OCCUPATIONAL THERAPISTS	F. HOME HEALTH AIDES	G. ALL OTHERS

BRANCH LOCATIONS (Identify each approved branch location. All branches must operate under the parent name. Continue on bottom of page if addtional room is needed.)

Address:	***Address:***	***Address:***
_____	_____	_____
_____	_____	_____
_____	_____	_____
Telephone No. _____	Telephone No. _____	Telephone No. _____
Supervising Nurse: _____	Supervising Nurse: _____	Supervising Nurse: _____

SUBUNIT LOCATIONS (Identify each subunit location, license number and Medicare provider number.)

_____	_____	_____
_____	_____	_____
_____	_____	_____
Telephone No. _____	Telephone No. _____	Telephone No. _____
Administrator: _____	Administrator: _____	Administrator: _____
Lic. No.: _____ Provider No.: _____	Lic. No.: _____ Provider No.: _____	Lic. No.: _____ Provider No.: _____

CERTIFICATION

_____ and _____
PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP — HOME HEALTH AGENCY ADMINISTRATOR

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge; and further gives assurance of the ability and intention of the

_____ Home Health Agency to comply with the
EXACT LEGAL NAME

regulations promulgated under the Missouri Home Health Agency Licensing Law (Chapter 197, RsMo. Cumulative 1983).

It is further certified that the _____ will comply with all recommendations
NAME OF AGENCY

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Home Health Agency.

SIGNATURES

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

HOME HEALTH AGENCY ADMINISTRATOR